33-LS0955\U
Wallace
4/5/24

CS FOR HOUSE BILL NO. 226(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES SUMNER, Himschoot, Ortiz

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance; relating to pharmacy benefits managers; relating to the Board of Pharmacy; relating to dispensing fees; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy, including independent monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) license and regulate the qualifications of entities and individuals engaged in the manufacture or distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent prescribing and administration of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board and an epinephrine auto-injector training program under AS 17.22.020(b);

(13) establish standards for the independent prescribing and dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist who dispenses a schedule II, III, or IV controlled substance under federal law to a person in the state register with the controlled substance prescription database under AS 17.30.200(n);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to

conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status**;**

(19) prohibit, limit, or provide conditions relating to the dispensing of a prescription drug that the United States Food and Drug Administration or the prescription drug's manufacturer has not approved for self-administration to ensure the effectiveness and security of a prescription drug to be administered by infusion or in a clinical setting.

*** Sec. 2.** AS 08.80.297(d)(2) is amended to read:

(2) "pharmacy benefits manager" has the meaning given in AS **21.27.975** [21.27.955].

*** Sec. 3.** AS 21.27.901 is amended to read:

Sec. 21.27.901. Registration of pharmacy benefits managers; scope of business practice. (a) A person may not conduct business in the state as a pharmacy benefits manager unless the person is registered with the director [AS A THIRD-PARTY ADMINISTRATOR UNDER AS 21.27.630].

(b) A pharmacy benefits manager registered under **this section** [AS 21.27.630] may

(1) contract with an insurer to administer or manage pharmacy benefits provided by an insurer for a covered person, including claims processing services for and audits of payments for prescription drugs and medical devices and supplies; **and**

(2) contract with network pharmacies [;

(3) SET THE COST OF MULTI-SOURCE GENERIC DRUGS UNDER AS 21.27.945; AND

(4) ADJUDICATE APPEALS RELATED TO MULTI-SOURCE GENERIC DRUG REIMBURSEMENT].

*** Sec. 4.** AS 21.27.901 is amended by adding new subsections to read:

(c) A pharmacy benefits manager

(1) shall apply for registration following the same procedures for licensure set out in AS 21.27.040;

(2) is subject to hearings and orders on violations; denial, nonrenewal, suspension, or revocation of registration; penalties; and surrender of registration under the procedures set out in AS 21.27.405 - 21.27.460.

(d) Each day that a pharmacy benefits manager conducts business in the state as a pharmacy benefits manager without being registered is a separate violation of this section, and each separate violation is subject to the maximum civil penalty under AS 21.97.020.

*** Sec. 5.** AS 21.27.905(a) is amended to read:

(a) A pharmacy benefits manager shall biennially renew a registration with the director **following the procedures for license renewal in AS 21.27.380**.

*** Sec. 6.** AS 21.27 is amended by adding a new section to read:

Sec. 21.27.907. Fiduciary duty. (a) A pharmacy benefits manager owes a fiduciary duty to a plan sponsor. A pharmacy benefits manager shall adhere to the practices set out in this section.

(b) A pharmacy benefits manager shall

(1) perform the manager's duties with care, skill, prudence, and diligence and in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims; and

(2) notify the plan sponsor in writing of any activity, policy, or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of interest with the duties imposed by this chapter.

(c) A pharmacy benefits manager that receives from a drug manufacturer or labeler a payment or benefit of any kind in connection with the use of a prescription drug by a covered person, including a payment or benefit based on volume of sales or market share, shall pass that payment or benefit on in full to the plan sponsor. This provision does not prohibit the insurer from agreeing by contract to compensate the pharmacy benefits manager by returning a portion of the benefit or payment to the pharmacy benefits manager.

(d) Upon request by a plan sponsor, a pharmacy benefits manager shall

(1) provide information showing the quantity of drugs purchased by the covered person and the net cost to the covered person for the drugs; the information must include all rebates, discounts, and other similar payments; if requested by the plan sponsor, the pharmacy benefits manager shall provide the quantity and net cost information on a drug-by-drug basis by National Drug Code registration number rather than on an aggregated basis; and

(2) disclose to the plan sponsor all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefits manager and a prescription drug manufacturer or labeler, including formulary management and drug-substitution programs, educational support, claims processing, and data sales fees.

(e) A pharmacy benefits manager providing information to a plan sponsor under (d) of this section may designate that information as confidential. Information designated as confidential may not be disclosed by the plan sponsor to another person without the consent of the pharmacy benefits manager, unless ordered by a court.

(f) If a pharmacy dispenses a substitute prescription drug for a prescribed drug to a covered person and the substitute prescription drug costs more than the prescribed drug, the pharmacy benefits manager shall disclose to the plan sponsor the cost of both drugs and any benefit or payment directly or indirectly accruing to the pharmacy benefits manager as a result of the substitution. The pharmacy benefits manager shall transfer in full to the plan sponsor a benefit or payment received in any form by the pharmacy benefits manager as a result of a prescription drug substitution.

*** Sec. 7.** AS 21.27.940 is amended to read:

Sec. 21.27.940. Pharmacy audits; restrictions. The requirements of AS 21.27.901 - **21.27.975** [21.27.955] do not apply to an audit

(1) in which suspected fraudulent activity or other intentional or wilful misrepresentation is evidenced by a physical review, a review of claims data, a statement, or another investigative method; or

(2) of claims paid for under the medical assistance program under AS 47.07.

*** Sec. 8.** AS 21.27.945(a) is amended to read:

(a) A pharmacy benefits manager shall

(1) **provide** [MAKE AVAILABLE] to each network pharmacy at the beginning of the term of the network pharmacy's contract, and upon renewal of the contract, the methodology and sources used to determine the [DRUG PRICING] list;

(2) provide the list to a network pharmacy without charge;

(3) [(2)] provide **and keep current** a telephone number at which a network pharmacy may contact an employee of a pharmacy benefits manager [TO DISCUSS THE PHARMACY'S APPEAL];

(4) [(3)] provide a process for a network pharmacy to have ready access to the list specific to that pharmacy;

(5) [(4)] review and update [APPLICABLE] list information at least once every seven [BUSINESS] days to **ensure** [REFLECT MODIFICATION OF] list pricing **reflects current national average drug acquisition cost**;

(6) [(5)] update list prices within one business day after a significant price update or modification provided by the pharmacy benefits manager's national drug database provider; and

(7) [(6)] ensure that dispensing fees are not included in the calculation of the list pricing.

*** Sec. 9.** AS 21.27.945(b) is repealed and reenacted to read:

(b) Before placing or maintaining a specific drug on the list, a pharmacy benefits manager shall ensure that

(1) if the drug is therapeutically equivalent and pharmaceutically equivalent to a prescribed drug, the drug is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the most recent edition or supplement of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(2) if the drug is a different biological product than a prescribed drug, the drug is an interchangeable biological product;

(3) the drug is readily available for purchase from national or regional wholesalers operating in the state; and

(4) the drug is not obsolete or temporarily unavailable.

*** Sec. 10.** AS 21.27.945 is amended by adding new subsections to read:

(c) The list a pharmacy benefits manager provides to a network pharmacy under (a) of this section must

(1) be maintained in a searchable electronic format that is accessible with a computer;

(2) identify each drug for which a reimbursement amount is established;

(3) specify for each drug

(A) the national drug code;

(B) the national average drug acquisition cost, if available;

(C) the wholesale acquisition cost, if available; and

(D) the reimbursement amount; and

(4) specify the date on which a drug is added or removed from the list.

(d) In this section,

(1) "interchangeable biological product" has the meaning given in AS 08.80.480;

(2) "pharmaceutically equivalent" means a drug has identical amounts of the same active chemical ingredients in the same dosage form and meets the standards of strength, quality, and purity according to the United States Pharmacopeia published by the United States Pharmacopeial Convention or another similar nationally recognized publication;

(3) "significant price update or modification" means

(A) an increase or decrease of 10 percent or more in the pharmacy acquisition cost from 60 percent or more of the pharmaceutical wholesalers doing business in the state;

(B) a change in the methodology in which the maximum allowable cost for a drug is determined; or

(C) a change in the value of a variable involved in the methodology used to determine the maximum allowable cost for a drug;

(4) "therapeutically equivalent" means a drug is from the same therapeutic class as another drug and, when administered in an appropriate amount,

provides the same therapeutic effect as, and is identical in duration and intensity to, the other drug;

(5) "therapeutic class" means a group of similar drug products that have the same or similar mechanisms of action and are used to treat a specific condition.

*** Sec. 11.** AS 21.27 is amended by adding new sections to read:

Sec. 21.27.951. Patient choice of pharmacy. (a) An insurer providing a covered person with a health care insurance plan and its pharmacy benefits manager may not

(1) prohibit or limit the person receiving pharmacy services under the insurer's health care insurance plan, including mail-order and specialty pharmacy services, from selecting a pharmacy of the person's choice to provide the pharmacy services if the pharmacy has notified the insurer, or the pharmacy benefits manager authorized to act on the insurer's behalf, of the pharmacy's agreement to accept as payment in full reimbursement for the pharmacy's services at rates applicable to pharmacies that are administered by the insurer or its pharmacy benefits manager, including any copayment required by the insurer's health care insurance plan;

(2) restrict access to drugs by limiting distribution of a drug through an affiliate, except to the extent necessary to meet limited distribution requirements of the United States Food and Drug Administration or to ensure the appropriate dispensing of a drug that requires extraordinary special handling, provider coordination, or patient education when those requirements cannot be met by a network pharmacy; an insurer or its pharmacy benefits manager who restricts drug access, or limits drug distribution under the exceptions allowed by this paragraph shall, upon request, promptly provide a pharmacy or pharmacist with a complete written description of all extraordinary special handling, provider coordination, and patient education requirements necessary for the distribution or dispensing of a drug; or

(3) use more restrictive criteria for an independent pharmacy than an affiliate under the insurer's health care insurance plan.

(b) An insurer or its pharmacy benefits manager shall act on a pharmacy's or pharmacist's request for a direct service agreement or a network pharmacy agreement

not later than 30 days after the insurer or its pharmacy benefits manager receives the pharmacy's or pharmacist's request or, if the insurer or its pharmacy benefits manager requests supplemental information, 30 days after the insurer or its pharmacy benefits manager receives the supplemental information.

(c) A network pharmacy or a pharmacy applying to become a network pharmacy under this section shall be presumed to meet the requirements of a specialty pharmacy upon providing documentation that it holds a federal certification demonstrating the ability to distribute specialty prescriptions.

(d) In this section,

(1) "specialty drug" means a drug that is subject to restricted distribution by the United States Food and Drug Administration;

(2) "specialty pharmacy" means a pharmacy capable of meeting the requirements of the United States Food and Drug Administration applicable to specialty drugs.

Sec. 21.27.952. Patient access to clinician-administered drugs. (a) An insurer or its pharmacy benefits manager may not

(1) refuse to authorize, approve, or pay a provider for providing covered clinician-administered drugs and related services to a covered person if the provider has agreed to participate in the insurer's health care insurance plan according to the terms offered by the insurer or its pharmacy benefits manager;

(2) if the criteria for medical necessity is met, condition, deny, restrict, refuse to authorize or approve, or reduce payment to a provider for a clinician-administered drug because the provider obtained the clinician-administered drug from a pharmacy that is not a network pharmacy in the insurer's or its pharmacy benefits manager's network;

(3) when a covered person is obtaining a clinician-administered drug from a network pharmacy authorized under the laws of this state to dispense or administer the drug, impose

(A) coverage or benefit limitations or require the covered person to pay an additional fee or a higher or additional copay or coinsurance to an affiliate pharmacy; or

(B) a penalty for using an independent pharmacy;

(4) require a covered person to pay an additional fee, a higher or additional copay or coinsurance, or another form of a price increase for a clinician-administered drug when the drug is not dispensed by a pharmacy or acquired from an entity selected by the insurer or its pharmacy benefits manager;

(5) interfere with the right of a covered person to obtain a clinician-administered drug from the provider or pharmacy of the person's choice, including by inducement, steering, or offering or promoting financial or other incentives;

(6) limit or exclude coverage for a clinician-administered drug when not dispensed by a pharmacy or acquired from an entity selected by the insurer or its pharmacy benefits manager when the drug would otherwise be covered;

(7) require or encourage the dispensing of a clinician-administered drug to a covered person in a manner that is inconsistent with the supply chain security controls and chain of distribution set by 21 U.S.C. 360eee - 360eee-4 (Drug Supply Chain Security Act);

(8) require that a clinician-administered drug be dispensed or administered to a covered person in the residence of the covered person or require use of an infusion site external to the office, department, or clinic of the provider of the covered person; nothing in this paragraph prohibits the insurer or its pharmacy benefits manager, or an agent of the insurer or its pharmacy benefits manager, from offering the use of a home infusion pharmacy or external infusion site.

(b) In this section, "clinician-administered drug" means a drug, other than a vaccine, that requires administration by a provider and that the United States Food and Drug Administration or the drug's manufacturer has not approved for self-administration.

Sec. 21.27.953. Penalties. In addition to any other penalty provided by law, if a person violates AS 21.27.945 - 21.27.975, the director may, after notice and hearing, impose a penalty in accordance with AS 21.27.440.

Sec. 21.27.954. Regulations relating to pharmacy benefits manager claims, grievances, activities, and appeals. The director shall adopt regulations that provide standards and criteria for

(1) the structure and operation of pharmacy benefits manager reimbursement of pharmacy claims under this chapter;

(2) procedures maintained by a pharmacy benefits manager to ensure that a pharmacy has the opportunity for appropriate resolution of grievances;

(3) an independent review of pharmacy benefits manager activities under this title; and

(4) requiring a pharmacy benefits manager to hear pricing appeals.

*** Sec. 12.** AS 21.27 is amended by adding new sections to article 9 to read:

Sec. 21.27.960. Defined cost sharing and prescription drugs. (a) A pharmacy benefits manager and agents of a pharmacy benefits manager shall ensure that a covered person's defined cost sharing for a prescription drug is calculated at the point of sale based on a price that is reduced by an amount equal to at least 85 percent of all rebates received, or that will be received, in connection with the dispensing or administration of the prescription drug. The pharmacy benefits manager or the agent of the pharmacy benefits manager shall ensure that a good faith estimate of the covered person's reduction in defined cost sharing required under this subsection is passed through to the covered person at the point of sale.

(b) The director or a pharmacy benefits manager may not impose liability, a penalty, or disciplinary action on a pharmacy or pharmacist for the pharmacy's or pharmacist's failure to reduce a covered person's defined cost sharing under (a) of this section if the covered person's health care insurer fails to provide the pharmacy or pharmacist with the information necessary to calculate the reduction. The health care insurer may not impose a monetary penalty on, or withhold a payment to, a pharmacy or pharmacist that engaged in good faith efforts to comply with (a) of this section.

(c) Nothing in this section prevents a health care insurer or an agent of a health care insurer from reducing a covered person's defined cost sharing by an amount greater than the amount calculated under (a) of this section.

(d) A pharmacy benefits manager may not be required to disclose the amount of rebates a health care insurer or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis, except as required to comply with this section. Information and records relating to the amount of rebates a

health insurer or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis are confidential for the purposes of AS 21.06.060.

(e) If a provision in this section conflicts with federal law, the provision does not apply to the extent of the conflict.

(f) The director may audit the books and records of a pharmacy benefits manager registered under this chapter to determine whether the pharmacy benefits manager has complied with the requirements of this section.

Sec. 21.27.975. Definitions. In AS 21.27.901 - 21.27.975,

(1) "affiliate" means a business, pharmacy, pharmacist, or provider who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a pharmacy benefits manager;

(2) "audit" means an official examination and verification of accounts and records;

(3) "claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device;

(4) "covered person" means an individual receiving medication coverage or reimbursement provided by an insurer or its pharmacy benefits manager under a health care insurance plan;

(5) "defined cost sharing" has the meaning given in AS 21.42.599;

(6) "drug" means a prescription drug;

(7) "extrapolation" means the practice of inferring a frequency or dollar amount of overpayments, underpayments, invalid claims, or other errors on any portion of claims submitted, based on the frequency or dollar amount of overpayments, underpayments, invalid claims, or other errors actually measured in a sample of claims;

(8) "health care insurance plan" has the meaning provided in AS 21.54.500;

(9) "health care insurer" means

(A) an insurer regulated by this title that offers health insurance

coverage as defined in 42 U.S.C. 300gg-91; or

(B) a state or local governmental plan;

(10) "independent pharmacy" means a pharmacy not affiliated with an insurer or pharmacy benefits manager;

(11) "insurer" has the meaning given in AS 21.97.900 and includes a company or group of companies under common management, ownership, or control;

(12) "list" means a list of drugs for which a pharmacy benefits manager has established predetermined reimbursement amounts, or methods for determining reimbursement amounts, to be paid to a network pharmacy or pharmacist for pharmacy services, such as a maximum allowable cost or maximum allowable cost list or any other list of prices used by a pharmacy benefits manager;

(13) "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a drug;

(14) "national average drug acquisition cost" means the average acquisition cost for outpatient drugs covered by Medicaid, as determined by a monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services;

(15) "network" means an entity that, through contracts or agreements with providers, provides or arranges for access by groups of covered persons to health care services by providers who are not otherwise or individually contracted directly with an insurer or its pharmacy benefits manager;

(16) "network pharmacy" means a pharmacy that provides covered health care services or supplies to an insured or a member under a contract with a network plan to act as a participating provider;

(17) "pharmacy" has the meaning given in AS 08.80.480;

(18) "pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler or distributor charges for a pharmaceutical product as listed on the pharmacy's invoice;

(19) "pharmacy benefits manager" means a person that

(A) contracts with a pharmacy on behalf of a health care insurer to process claims or pay pharmacies for prescription drugs or medical

devices and supplies or provide network management for pharmacies; or

(B) contracts with or is employed by a health care insurer, either directly or through an intermediary, to manage a prescription drug benefit provided by the health care insurer, including the processing and payment of claims for prescription drugs, performance of prescription drug utilization review, processing of drug prior authorization requests, adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, or otherwise controlling the cost of prescription drugs;

(20) "plan sponsor" has the meaning given in AS 21.54.500;

(21) "provider" means a physician, pharmacist, hospital, clinic, hospital outpatient department, pharmacy, or other person licensed or otherwise authorized in this state to furnish health care services;

(22) "rebate" has the meaning given in AS 21.42.599;

(23) "recoupment" means the amount that a pharmacy must remit to a pharmacy benefits manager when the pharmacy benefits manager has determined that an overpayment to the pharmacy has occurred;

(24) "wholesale acquisition cost" has the meaning given in 42 U.S.C. 1395w-3a(c)(6)(B).

*** Sec. 13.** AS 21.36 is amended by adding a new section to article 5 to read:

Sec. 21.36.520. Unfair trade practices. (a) An insurer providing a health care insurance plan or its pharmacy benefits manager may not

(1) violate AS 21.27.950;

(2) interfere with a covered person's right to choose a pharmacy or provider as provided in AS 21.27.951;

(3) interfere with a covered person's right of access to a clinician-administered drug as provided in AS 21.27.952;

(4) interfere with the right of a pharmacy or pharmacist to participate as a network pharmacy as provided in AS 21.27.951;

(5) reimburse a pharmacy or pharmacist an amount less than the amount the pharmacy benefits manager reimburses an affiliate for providing the same

pharmacy services, calculated on a per-unit basis using the same generic product identifier or generic code number;

(6) impose a reduction in reimbursement for pharmacy services because of the person's choice among pharmacies that have agreed to participate in the plan according to the terms offered by the insurer or its pharmacy benefits manager;

(7) use a covered person's pharmacy services data collected under the provision of claims processing services for the purpose of soliciting, marketing, or referring the person to an affiliate of the pharmacy benefits manager;

(8) require a covered person, as a condition of payment or reimbursement, to purchase pharmacist services or products, including drugs, through a mail-order pharmacy or pharmacy benefits manager affiliate;

(9) prohibit or limit a network pharmacy from mailing, shipping, or delivering drugs to a patient as an ancillary service; however, the insurer or its pharmacy benefits manager

(A) is not required to reimburse a delivery fee charged by a pharmacy unless the fee is specified in the contract between the pharmacy benefits manager and the pharmacy;

(B) may not require a patient signature as proof of delivery of a mailed or shipped drug if the network pharmacy

(i) maintains a mailing or shipping log signed by a representative of the pharmacy or keeps a record of each notification of delivery provided by the United States mail or a package delivery service; and

(ii) is responsible for the cost of mailing, shipping, or delivering a replacement for a drug that was mailed or shipped but not received by the covered person;

(10) impose on a pharmacist or pharmacy seeking to remain or become a network provider credentialing standards that are more strict than the licensing standards set by the Board of Pharmacy or charge a pharmacy a fee in connection with network enrollment;

(11) prohibit or limit a network pharmacy from informing an insured

person of the difference between the out-of-pocket cost to the covered person to purchase a drug, medical device, or supply using the covered person's pharmacy benefits and the pharmacy's usual and customary charge for the drug, medical device, or supply;

(12) conduct or participate in spread pricing in the state;

(13) assess, charge, or collect a form of remuneration that passes from a pharmacy or a pharmacist in a pharmacy network to the pharmacy benefits manager including claim processing fees, performance-based fees, network participation fees, or accreditation fees;

(14) reverse and resubmit the claim of a pharmacy more than 90 days after the date the claim was first adjudicated, and may not reverse and resubmit the claim of a pharmacy unless the insurer or pharmacy benefits manager

(A) provides prior written notification to the pharmacy;

(B) has just cause;

(C) first attempts to reconcile the claim with the pharmacy; and

(D) provides to the pharmacy, at the time of the reversal and resubmittal, a written description that includes details of and justification for the reversal and resubmittal.

(b) A provision of a contract between a pharmacy benefits manager and a pharmacy or pharmacist that is contrary to a requirement of this section is null, void, and unenforceable in this state.

(c) A violation of this section or a regulation adopted under this section is an unfair trade practice and subject to penalty under this chapter.

(d) For purposes of this section, a violation has occurred each time a prohibited act is committed.

(e) Nothing in this section may interfere with or violate a patient's right under AS 08.80.297 to know where the patient may have access to the lowest cost drugs or the requirement that a patient must receive notice of a change to a pharmacy network, including the addition of a new pharmacy or removal of an existing pharmacy from a pharmacy network.

(f) The director may adopt regulations to provide an appeals process for

claims adjudicated under this section.

(g) In this section,

(1) "affiliate" has the meaning given in AS 21.27.975;

(2) "clinician-administered drug" has the meaning given in AS 21.27.952(b);

(3) "covered person" has the meaning given in AS 21.27.975;

(4) "drug" has the meaning given in AS 21.27.975;

(5) "health care insurance plan" has the meaning given in AS 21.54.500;

(6) "insurer" has the meaning given in AS 21.27.975;

(7) "mail-order pharmacy" means a pharmacy whose primary business is to receive drugs by mail or through electronic submission and to dispense medication to a covered person through the use of the United States mail or other common or contract carrier services and who may provide consultation with a covered person electronically rather than face-to-face;

(8) "network pharmacy" has the meaning given in AS 21.27.975;

(9) "out-of-pocket cost" means a deductible, coinsurance, copayment, or similar expense owed by a covered person under the terms of the covered person's health care insurance plan;

(10) "provider" has the meaning given in AS 21.27.975;

(11) "spread pricing" means the method of pricing a drug in which the contracted price for a drug that a pharmacy benefits manager charges a health care insurance plan differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

*** Sec. 14.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.435. Defined cost sharing and prescription drugs. (a) A health care insurer and agents of a health care insurer shall ensure that a covered person's defined cost sharing for a prescription drug is calculated at the point of sale based on a price that is reduced by an amount equal to at least 85 percent of all rebates received, or that will be received, in connection with the dispensing or administration of the prescription drug. The health care insurer or the agent of the health care insurer shall

ensure that a good faith estimate of the covered person's reduction in defined cost sharing required under this subsection is passed through to the covered person at the point of sale.

(b) The director or a health care insurer may not impose liability, a penalty, or disciplinary action on a pharmacy or pharmacist for the pharmacy's or pharmacist's failure to reduce a covered person's defined cost sharing under (a) of this section if the covered person's health care insurer fails to provide the pharmacy or pharmacist with the information necessary to calculate the reduction. The health care insurer may not impose a monetary penalty on, or withhold a payment to, a pharmacy or pharmacist that engaged in good faith efforts to comply with (a) of this section.

(c) Nothing in this section prevents a health care insurer or an agent of a health care insurer from reducing a covered person's defined cost sharing by an amount greater than the amount calculated under (a) of this section.

(d) A health care insurer or an agent of a health care insurer may not be required to disclose the amount of rebates a health care insurer or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis, except as required to comply with this section. Information and records relating to the amount of rebates a health insurer or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis are confidential for the purposes of AS 21.06.060.

(e) If a provision in this section conflicts with federal law, the provision does not apply to the extent of the conflict.

(f) The director may audit the books and records of a health care insurer to determine whether the health care insurer has complied with the requirements of this section.

(g) In this section, "health care insurer" has the meaning given in AS 21.27.975.

*** Sec. 15.** AS 21.42.599 is amended by adding new paragraphs to read:

(9) "defined cost sharing" means a deductible payment, coinsurance, or similar amount owed by a covered person under the terms of the covered person's health care insurance plan;

(10) "negotiated price concession" includes a base price concession or reasonable estimate of any price protection rebate and performance-based price concession that may accrue directly or indirectly to a health care insurer during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug;

(11) "price protection rebate" means a negotiated price concession that accrues directly or indirectly to the health care insurer, or another person on behalf of the health care insurer, in the event of an increase in the wholesale acquisition cost of a drug above a threshold specified in a contract to which the health care insurer, or another person on behalf of the health care insurer, is a party;

(12) "rebate" means a

(A) negotiated price concession, whether or not the negotiated price concession is described as a rebate or accrues directly or indirectly to a health care insurer during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug; or

(B) reasonable estimate of any negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the health care insurer and serve to reduce the health care insurer's prescription drug liabilities.

*** Sec. 16.** AS 39.30 is amended by adding a new section to read:

Sec. 39.30.032. Coverage for dispensing fees. The director of the division of insurance shall periodically review dispensing fees paid under coverage provided to individuals entitled to medical benefits under AS 39.30.091 and available cost of dispensing surveys, including surveys conducted by the Department of Health for the medical assistance program under AS 47.07 and the national average drug acquisiton cost retail price survey conducted by the federal Centers for Medicare and Medicaid Services. The director shall negotiate dispensing fees with independent pharmacies and tribal health pharmacy providers to ensure availability of prescription medications to individuals entitled to medical benefits under AS 39.30.091. The director may establish differential dispensing fees to expand availability of pharmacies in remote

communities, communities without access to the road system, communities with small populations, neighborhoods experiencing high rates of poverty, and neighborhoods with low rates of car ownership. The director shall set and adjust dispensing fees accordingly. The director shall adjust dispensing fees at least once every five years.

*** Sec. 17.** AS 45.50.471(b) is amended by adding a new paragraph to read:

(58) violating AS 21.36.520(a) (insurers and pharmacy benefits managers), if the violation is committed or performed with a frequency that indicates a general business practice.

*** Sec. 18.** AS 21.27.950 and 21.27.955 are repealed.

*** Sec. 19.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to an insurance policy or contract, including a contract between a pharmacy benefits manager and a pharmacy or pharmacist, issued, delivered, entered into, renewed, or amended on or after the effective date of secs. 1 - 18 of this Act.

*** Sec. 20.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Commerce, Community, and Economic Development and the Department of Administration may adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law implemented by the regulation.

*** Sec. 21.** Section 20 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 22.** Except as provided in sec. 21 of this Act, this Act takes effect July 1, 2025.